GUARDIAN

CUSTOMER INFORMATION

Name	
Address	
Account Number	
Daytime Contact	Name: Phone:

PROGRAM GUIDELINES

Guardian provides monthly bill discounts for customers with doctor prescribed electrically powered medical equipment and space conditioning needs. Discounts are not authorized for devices used for therapeutic purposes, such as whirlpool pumps, heating pads, vaporizers, humidifiers, pool or tank heaters, saunas, hot tubs, medical devices used outside the home, and non-electric powered medical devices. Equipment not listed above may be approved on a case by case basis.

The following eligibility requirements apply:

1. Must be a GWP electric customer.
2. Medical equipment must be electrically powered and prescribed by a doctor.
3. Participant must reapply each time they move and recertify eligibility annually or when requested.
4. Participant must notify GWP within thirty (30) days if they become ineligible for the program.
5. Must allow GWP access to the home to determine the manufacturer and ampere if requested by GWP.
6. Must acknowledge that GWP does not guarantee continuous power, and declare the number of hours of emergency backup arranged for by the customer.
7. Eligible medical equipment includes:

Aerosol Tents	Extremity Pump	Kidney Dialysis
Apnea Monitors	Hemodialysis	Motorized Wheelchairs
Blood Pump	Heparin Pump	Nerve Stimulators
Nebulizers	Infusion Pump	Oxygen Concentrators
Reverse Osmosis	Suction Machines	Ventilators
Respirators	Iron Lung	Pressure Pumps

8. Customers with special medically prescribed electric heat or air conditioning needs may also be eligible for the program on a case by case basis. Eligible conditions include households with paraplegic, quadriplegic, or hemiplegic members and/or households with members suffering from scleroderma and/or multiple sclerosis.

MUST COMPLETE AND SIGN REVERSE

MEDICAL EQUIPMENT INFORMATION

Information regarding the amperes, manufacturer, and model number can be found on the medal faceplate attached to the outside surface of the device.

1. Medical Equipment Name	Manufacturer/Model Number	
Equipment Provider Telephone Number	Amperes	Hours Used Per Day
2. Medical Equipment Name	Manufacturer/Model Number	
Equipment Provider Telephone Number	Amperes	Hours Used Per Day
3. Medical Equipment Name	Manufacturer/Model Number	
Equipment Provider Telephone Number	Amperes	Hours Used Per Day

I hereby apply for the Guardian discount, and certify under penalty of perjury that the information provided herein is truthful and accurate to the best of my knowledge. I understand that providing misinformation can disqualify me for this and other PBC programs, and that GWP CANNOT GUARANTEE CONTINUOUS ELECTRIC SERVICE. IT IS MY RESPONSIBILITY TO MAKE BACKUP ARRANGEMENTS IN CASE OF A POWER OUTAGE. I further agree to give GWP access to my home to determine the manufacturer and ampere rating of my equipment if none is supplied, and for program auditing purposes.

I HAVE MADE ARRANGEMENTS FOR _____ HOURS OF EMERGENCY COVERAGE.

SIGNATURE OF GWP ACCOUNT CUSTOMER **DATE**

MEDICAL DOCTOR SECTION ONLY

This section is to be completed by the prescribing medical doctor of the person living in the household with the special medical equipment or space conditioning need

PATIENT'S NAME: _____

Patient has ***sclerodema*** ***multiple sclerosis*** (CIRCLE) requiring special space heating.

Patient is a ***paraplegic*** ***quadriplegic*** ***hemiplegic*** (CIRCLE) requiring special space cooling.

Patient suffers from _____
and requires the following medical equipment:

Type of Equipment Prescribed	Hours Per Day	Months/Lifetime
1.		
2.		
3.		

ONE OR MORE OF THE ABOVE ITEMS OR CONDITIONS IS CONSIDERED NECESSARY FOR LIFE SUPPORT **Circle** YES NO

SIGNATURE OF THE PRESCRIBING DOCTOR **DATE**

PRINT NAME, PHONE, AND MEDICAL LICENSE NUMBER